State Request for Approval of Use of Civil Money Penalty Funds for Certified Nursing Homes: Region X/Seattle

Palliative Care Institute

Please see Region X/Seattle application form for all demographic information. Please note that the Medicaid Provider Number for Christian Health Care Center is 4113221. There were not enough boxes in the form to list the whole number.

The required cover letter to the State Agency Director is also with the application is attached.

PART VII – EXPECTED OUTCOMES
PROJECT ABSTRACT
Requesters' Background and Qualifications:

Marie Eaton, PhD, Director of the Palliative Care Institute at Western Washington University, chaired the original Task Force that developed the *Blueprint for Creating a Community of Care and Support for People with Serious Illness.*[1] Also current Chair of the Northwest Life Passages Coalition.

Tonja Myers, BA, Administrator. Christian Health Care Center (CHCC). A Licensed Nursing Home Administrator (LNHA) since 1988. She served in leadership positions with the Washington Health Care Association and is currently President of the Whatcom Hospice Foundation and Chairperson of the Northwest Workforce Development Council.

Need: As more members of our community age, palliative and end-of-life care is increasingly important so that patients approaching death can live each moment as well as possible. Current nursing home culture does not foster shifting to palliation when patients are actively dying. Most available palliative training focuses exclusively on physicians, nurses and other licensed professionals, yet in U.S. nursing homes, nurse aides, certified nursing assistants (NACs) and orderlies account for nearly two-thirds of care staff. These caregivers with minimal education have little access to continuing education. And there is often no training or orientation in end-of-life issues for the other support staff, such as dietary, housekeeping and maintenance workers.

Through this project, we intend to demonstrate that **including support staff and NACs in palliative end-of-life care training will effect** ***facility-wide paradigm shifts*** **needed to create a** ***system-wide change*** **in how skilled nursing facilities handle end of life care.**

Additionally, excessive, unwarranted end-of-life care expenditures drive up the cost of the U.S. health care system. For every 100 elderly patients in a skilled nursing facility in a given year, 35 die in care and 37 are admitted to a hospital. **Cultivating a palliative facility culture may decrease referral to unneeded or unwanted heroic interventions, thereby reducing end-of-life expenditures**.

[1] http://whatcomalliance.org/wp-content/uploads/2017/12/20170116NWLPBlueprint.pdf

GOALS

- Foster facility wide improvements in palliative care across all staff levels
- Enhance patients' access to treatment aligned with their end-of-life choices by increasing:
    - availability of palliative care in advance of Medicare qualification for hospice
    - timely referrals to hospice services
    - improved nursing-home-based palliative care when hospice staff are not on site
- Lower end-of-life expenditures by increasing patients' access to palliative care
- Improve staff retention statistics

Project evaluation - This project will be evaluated through a number of measures: phone interviews with families of nursing home residents who have received end-of-life care at the facility pre-and post-training; surveys and focus groups to assess staff attitudes across all job roles about end-of-life care and knowledge in palliative care competencies pre-and post-training; data on staff retention pre-and post-training. Project evaluation will be conducted by the Touch of Grace planning group, led by Marie Eaton. (See *Section XII – Organizations* for a full membership list of the Touch of Grace planning group.)

STATEMENT OF NEED - PROBLEMS TO BE ADDRESSED:

IMPROVEMENT IN END-OF-LIFE CARE IN SKILLED NURSING FACILITIES: In a recent meta-analysis of nursing home care, a clear and urgent need to design educational interventions that have the potential to improve end-of-life care in nursing homes was identified.[2]

Our society's approach to dying has changed dramatically over the past fifty years, but the medical and social systems that support us as we approach the end of life have not kept up. Institutions we rely upon -- hospitals, nursing homes, medical schools, Medicare, and others -- have, by and large, failed to evolve sufficiently to reflect our values and choices for end of life care.

As Alan R. Weil, Director of the Aspen Institute, notes in his *Report on Improving Care at the End of Life*: "While leaders in each of these sectors are showing the way to a health care system that supports people and their families as they face advanced illness and death, the pace of change is far too slow. The consequences can be seen in the unneeded suffering of millions of Americans as they experience advanced illness and approach death.[3]

Most skilled nursing facility staff do not have adequate training on shifting from care that emphasizes staying alive to care that supports respectful, culturally responsive dying. This lack of training in palliative practices impacts a growing number of people in our communities.

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[2] Anstey S, Powell T, Coles B, *et al*. Education and training to enhance end-of-life care for nursing home staff: a systematic literature review. *BMJ Supportive & Palliative Care* Published Online First: 21 June 2016. doi: 10.1136/bmjspcare-2015-000956

[3] https://assets.aspeninstitute.org/content/uploads/2017/02/AHSG-Report-Improving-Care-at-the-End-of-Life.pdf

According to the Kaiser Foundation's 2015 report, there are 1.4 million people in nursing homes nationally.[4] By 2050, the number of individuals needing these long-term care services will likely double, influenced by growth in the population of older people in need of care.[5] Approximately 60% of those who enter nursing homes stay more than a year (35% of those admitted die in care and another 37% are admitted to a hospital where they may die, recover, or be re-admitted to a nursing home.)[6]

POTENTIAL PROBLEMS IN IMPLEMENTATION (including contingencies for managing)

One potential problem is the challenge of pulling staff from their daily assignments to offer this education. This project is designed so the education is available in small sections online, so we believe staff will be able to access the modules easily and will not have to spend too much time off the floor. Another potential problem is the high turn-over all nursing home facilities experience will require continued training. Once the curriculum is validated, we plan to make this education available in a format that can be used and repeated easily and eventually can be integrated in to facility orientation processes.

PROGRAM DESCRIPTION

OBJECTIVES - Complete curriculum development and begin implementation of *Touch of Grace,* a pilot training program on palliative end-of-life care for nursing home and assisted living staff, which could be replicated nationally. Training will:

- increase understanding of palliative care in both professional and non-professional staff
- shift staff attitudes and behaviors toward a culture where a palliative approach is welcome and supported

PHASE ONE: (CURRICULUM DEVELOPMENT) IS FULLY FUNDED (NON-CMP) - Chuckanut Health Foundation $15,000; individuals $6,000; Whatcom Women in Business $1,000; Alzheimer Society of Washington $650; Western Washington University: in-kind

Phase 1 - By August 31, 2018

1. Develop curriculum in on-line modules suitable for training support staff, NACs and professional nursing home staff to build knowledge and comfort about palliative care

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[4] The Henry J. Kaiser Family Foundation (2011) Number of Nursing Facility Residents. Retrieved (January 2015) from <https://www.kff.org/>

[5] U.S. Department of Health and Human Services, and U.S. Department of Labor. The future supply of long-term care workers in relation to the aging baby boom generation: Report to Congress. Washington, DC: Office of the Assistant Secretary for Planning and Evaluation, (2003).

[6] https://www.longtermcarelink.net/eldercare/nursing_home.htm

2. Complete continuing-education qualification applications
3. Design a robust evaluation protocol for demonstrating impact on facility, staff and families and collect pre-training data.

PHASE TWO: (IMPLEMENTATION AND VALIDATION) PROPOSED CMP FUNDING

Phase 2: September 1, 2018–August 31, 2019
Implement pilot training program with Certified Nursing Assistants (NAC) and Support Staff (eg. Housekeeping, Maintenance, Dietary) in 230-employee facility to develop new attitudes and protocols for working with patients who have entered the active dying phase. *Touch of Grace* short, online modules will be accessible by staff on their own timelines but on-the-clock. Hospice staff will facilitate discussions across job groups during shift straddle times. Facility-wide procedural changes will be introduced, for example use of a magnetic visual cue for door jambs that signals when a patient is actively dying.

- ✓ **Training Modules** target support staff and NACs. Draft topics: *Roles of Support Staff and NCAs in Palliative & Hospice Care; Communication between Support Staff/NCAs and Residents/Families; Role of Staff/NCAs in Pain/Symptom Management; Role of Staff/NCAs during Final Hours; Loss, Grief & Bereavement.* (See Appendix A for content outline.)
- ✓ **Train the Trainers** targets leadership responsible for incorporating training into new-hire orientation.

Conduct post-training assessment to evaluate changes in staff attitudes and intervention choices and staff retention and family experience.

In subsequent phases, we will
1. Revise curriculum based on pilot evaluation results
2. Implement in three additional facilities
3. Evaluate
4. Disseminate results to medical providers and public policy leaders to advocate that palliative care be incorporated into training for medical and social service providers at all levels

LESSONS IF SUCCESSFUL

We will demonstrate that:

- Palliative care competencies appropriate to their positions can be taught to staff across all job roles
- Caregivers with minimal education and little access to continuing education can benefit from this training
- Changes in facility culture can be accomplished by training non-professional staff in a subject previously considered outside their concerns
- Hospice providers, who are mandated by the Center for Medicare/Medicaid Services to train nursing home staff in palliative care, find this curriculum effective

LESSONS IF UNSUCCESSFUL

We will develop a better understanding of the challenges in training non-professional staff and identify barriers to collaborations between professional and non-professional staff.

PART VIII – RESULTS MEASUREMENT

This project will be evaluated through a number of Pre- and Post- measures:

1. Phone interviews with families of nursing home residents who have received end-of-life care at the facility;
2. Staff surveys and focus groups to assess attitudes about end-of-life care and knowledge in palliative care competencies;
3. Data on staff retention.

Project evaluation will be conducted by the Touch of Grace planning group, led by Marie Eaton. (See *Section XII – Organizations* for a full membership list of the Touch of Grace planning group.)

PART XI – BENEFITS TO NURSING HOME RESIDENTS

Although some skilled nursing facilities work closely with hospice providers, unfortunately, under current reimbursement streams, many patients are not enrolled or are not eligible for hospice and thus do not benefit from palliative end-of-life care, and many staff have little or no training in this kind of care.

> *An elderly nursing home resident*'s *health has declined precipitously in the past three weeks. One night he is having trouble breathing, so the person in charge calls 9-1-1 and the patient is transported to the hospital emergency room. Hours of effort to save him fail and he dies before his family can reach his bedside. Several weeks later, his son asks whether his father could have qualified for hospice care and the nursing home social worker responds "perhaps—we didn't look into that."*

One avenue for better care for all nursing home and assisted living patients is to develop a facility culture and training so all staff are better prepared to support palliative end-of-life support and care consistent with their job roles. The Northwest Life Passages Coalition's *Blueprint for Creating a Community of Care and Support for People with Serious Illness* recommends this kind of enhanced provider training.[7]

The needs addressed by this project are both local and national in scope. Although many other organizations are developing training in palliative care for medical professionals and clinical providers, it is necessary to adapt this content and design a training structure that will be effective in training nonprofessional staff in order to create a facility culture that fosters palliative care.

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[7] http://whatcomalliance.org/wp-content/uploads/2016/03/Revised-Blueprint-2016.11.pdf

On a national level, hospices are mandated by the Center for Medicare/Medicaid Services (CMS) to train staff of nursing home facilities in palliative care. "The hospice staff must assure orientation of Long Term Care facility staff on hospice philosophy, hospice policies and procedures, principals of death and dying."[8] But as noted previously, most of the available curriculum focuses on clinical and professional staff; the development of curriculum and training program for non-professional and NAC staff will fill an important gap.

Also, on a national level, increasing the availability of palliative care is a critical component in controlling the cost of health care, which averages $60,000 in the last year of life for Medicare beneficiaries and is more than three times higher when provided as a hospital inpatient rather than in either a skilled nursing facility or hospice.[9]

Finally, we believe this project may also have an impact on advancing health equity. Significant disparities in access to palliative care exist for minority communities. Nearly 20% of skilled nursing facility residents are Hispanic, black or Asian. When providers and patients differ in culture, religion, and ethnicity, providers are less likely to explain palliative care. *Touch of Grace* topics include culturally responsive care.

Also, many uncertified staff in nursing homes come from minority communities. Staff turnover is high—almost 50% for RNs and nearly 100% for aides. Resulting costs for staff, institutions, or residents include lost income, decrease in staff morale, increased work stress, job dissatisfaction, high employee replacement costs, loss of productivity, poorer quality of care, increased hospital readmission rates, and resident and family dissatisfaction.

We hope to demonstrate that training in palliative end-of-life care improves work retention rates. Working with dying patients is stressful; enhanced training reduces stress by developing confidence in administering comfort care and support, and by creating a peer group with whom to talk about the anxieties of providing such care. *Touch of Grace* incorporates methods proven effective in mitigating high turnover: involvement in interdisciplinary care meetings, modeling exemplary care for aides, opportunities for professional growth, enhanced orientation, perception of being valued, and being an important part of the team.

PART X – CONSUMER/STAKEHOLDER INVOLVEMENT

The Governing Body at CHCC (the CEO and Board of Directors) are aware of and supportive of our project. Once baseline data collection is complete and implementation has begun, the resident council will be apprised of the new project. CHCC does not have a Family Council at this time, but as noted previously, the assessment data includes family feedback. We have also spoken to various local community groups, such as Kiwanis, as part of our out-reach and education about end-of-life care. Our goal is a culture shift.

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[8] https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/downloads/R65SOMA.pdf

[9] Medicare Beneficiary Summary File (MBSF), 2011-2013 www.resdac.org/cms-data/files/mbsf

PART XI- FUNDING

Project Budget (WWU Foundation on behalf of the Palliative Care Institute and Christian Health Care Center)

Touch of Grace: A pilot training program on palliative end-of-life care for Certified Nursing Assistants and Support Staff in nursing homes

EXPENSES			
PERSONNEL	**Current Rate**	**Month s**	**4.25%**
Personnel Salaries			
PI: Project Manager	$10,555.53	30.0%	$3,301.24
Staff position: "Training Curriculum Director":			
Discussion facilitation	$5,166.67	14.3%	$770.23
Train the trainers	$5,166.67	2.7%	$145.43
Assessment development	$5,166.67	11.9%	$640.96
Coding data and revision recommendations	$5,166.67	23.8%	$1,281.93
Curriculum revision	$5,166.67	0.0%	$0.00
Staff: administrative support	$4,000.00	154.8%	$6,455.16
Subtotal, salaries			**$12,595**
Personnel Fringe Benefits			
PI: Project Manager	30%		$ 990.37
Staff: Discussion facilitation	45%		$ 346.60
Staff: Train the trainers	45%		$ 65.44
Staff: Assessment development	45%		$ 288.43
Staff: Coding data and revision recommendations	45%		$ 576.87
Staff: Curriculum revision	45%		$

			-
Staff: Administrative Assistant	45%		$ 2,904.82
Subtotal, benefits			**$5,173**
TOTAL PERSONNEL (Salary and fringe)			**$17,768**
OTHER DIRECT COSTS	**Rate**	**Units**	
Travel (domestic)			
Vehicle reimbursement for personnel	$ 0.535	3,172.0	$ 1,697.02
Travel to conferences to disseminate results (estimated)			$ 3,500.00
Subtotal, Travel			**$5,197**
Healthy food for discussion sessions	$55.00	32.0	$1,760.00
Other: Printing/Copying			$100
TOTAL OTHER DIRECT COSTS			**$7,057**
PURCHASED SERVICES			
Reimbursement to Christian Health Care Center to compensate employees for training time (salary and benefits):			
Non-licensed employees- Support Staff (Phase Two: 115 Christian Health Care Center employees will watch 5 online modules, each 50 minutes; plus attend 2 group discussions, each 30 minutes)			$10,449.81

33.65/min			
Nursing Assistants - Certified (Phase Two: 90 Christian Health Care Centeremployees will watch 5 online modules, each 50 minutes; plus attend 2 group discussions, each 30 minutes) 53.17/min			$ 16,495.35
Total reimbursement (Phase Three assumes cost = 3 x Phase Two)			
TOTAL PURCHASED SERVICES			**$26,945**
TOTAL DIRECT COSTS			**$51,770**
REIMBURSABLE INDIRECT COSTS			
DHHS negotiated rate of 52.2% of Personnel without Fringe	52.2%	$12,595	$ 6,574.59
TOTAL REIMBURSABLE INDIRECT COSTS			**$6,575**
TOTAL			**$58,345**

PART XII – INVOLVED ORGANIZATIONS

Organizations receiving funding:

Palliative Care Institute, Western Washington University, 516 High Street, Bellingham, WA 98225-9088

Contact: Marie Eaton, Director. marie.eaton@wwu.edu 360-671-6371

Christian Health Care Center, 855 Aaron Drive, Lynden, WA 98264

Contact: Tonja Myers, Administrator. tamyers@chcclynden.org 360-354-4434

Sub-contractors, responsible for curriculum implementation (see bios below):

Bonnie Blachly, Faculty, RN-BSN Nursing Program, University of Washington

Laura Hofmann, Director, Cinical And Nursing Facility Regulatory Services, Leading Age Washington

Jodi Newcomer, Assistant Nurse Manager at Whatcom Hospice

Planning Group: *Touch of Grace* is being developed in collaboration with the local hospital, hospice, nursing programs, nursing home administrators and other community groups.

Since Summer 2016 the following partners have been meeting to explore models for in-service training in palliative and end-of-life for nursing home and assisted living staff:

- Jodi Newcomer, Assistant Nurse Manager at Whatcom Hospice
- Debbie Gann, Director, Home Attendant Care
- Tonja Myers, Administrator, Christian Health Care Center, Lynden, WA
- Bonnie Blachly, Faculty, RN-BSN Nursing Program, University of Washington
- Claudia Fischer, Palliative Care Team, PeaceHealth
- Laura Hofmann, Director, Cinical And Nursing Facility Regulatory Services, Leading Age Washington
- Cori Garcia-Hansen, Director, Area Health Education Center (AHEC) for Western Washington
- Marie Eaton, Director, Palliative Care Institute, Western Washington University

These partners will continue to work collaboratively as an advisory group for the project in developing, implementing, evaluating, and disseminating information about the training program. All partners will be involved in the planning process to determine:

- how to address the significant challenge of training caregivers who often have minimal education and less access to continuing education
- the number of hours of training and right size and characteristics of a pilot cohort to demonstrate and measure impact
- how to meet the financial challenges of both the employees and institutions for which they work, to ensure optimal participation in order to transform institutional culture.

These partners also will work collaboratively to continue to research current palliative and end-of-life training programs and review the adapted curriculum and competencies to be offered on-site in nursing homes and assisted living facilities. The planning group will also focus on solving any challenges that could stand in the way of successful implementation of the pilot program or broader implementation during subsequent phases.

Bonnie Blachly, MN, RN has a background in long-term care and community-based care. She is currently a faculty member in the RN-BSN Nursing Program at Western Washington University, where she teaches courses including “Community-Based Care for Vulnerable Populations,” “Care Coordination” and “Death and Dying.” Over her career she has worked as a bedside nurse, a Clinical Coordinator, Director of Nursing and a Nursing Home Administrator. She has also worked as an Agency Director for Home Health and as the Director of Clinical and Regulatory

Services for Aging Services of Washington, an association representing non-profit skilled nursing facilities, assisted living and independent living communities and continuing care retirement communities. She has recently been certified as a Core Trainer at the End-of-Life Nursing Education Consortium (ELNEC). She has worked on a number of state and local committees to develop strategies to improve care at the end of life including the Washington State POLST committee and the WSHA committee to reduce unnecessary hospitalizations. She has special interest in end-of-life care and as a teacher working with students, conducted a number of Death Cafes and Death Over Dinner events. She is also an Advanced Care Plan Trainer in Snohomish County. Her inspiration in working with the end-of-life population relates to her personal experiences in death and dying having lost her youngest brother, mother, and most recently her brother-in-law.

Laura Hofmann, MSN, RN, is Director of Clinical and Nursing Facility Regulatory Services at Leading Age Washington. She brings over 20 years of registered nursing practice in skilled nursing facilities and her work on federal and state policy and clinical practices supporting resident health outcomes in both skilled nursing facilities and assisted living. She has expertise in identifying areas of clinical focus for improved outcomes and reduced hospitalizations. She also understands the changing health care environment and is eager to address and identify solutions to the workforce challenges we face in long-term supports and services.

Jodi Newcomer, RN, Nurse Manager at Whatcom Hospice. Jodi has been an RN for 23 years, with 13 years experience in oncology and 10 in hospice care. She serves on the Board of Directors for The Washington State Hospice and Palliative Care Organization.

Appendix A: Training Goals for

Touch of Grace: A pilot training program on palliative end-of-life care for Nursing Assistants Certified and Support Staff in nursing homes

All training materials will be available on-line and self-paced by the individual. This training materials will be augmented by a discussion session on each Module facilitated by Hospice or other trained staff.

I. MODULE ONE: The Role of Support Staff and Nursing Assistants Certified (NAC) in Palliative Care & Hospice Care
  a. Objectives
    i. Participants will be able to define Palliative Care.
    ii. Participants will be able to define Hospice Care.
    iii. Participants will be able to explain the difference between Palliative Care & Hospice Care.
    iv. Participants will be able to identify 2 ways to support residents and families during this time.
  b. Content topics
    i. What is Palliative Care
    ii. What is Hospice Care
    iii. Role of support staff and NAC's during these times
      1. Can be the eyes and ears for a Hospice Referral so add content related to this.
      2. How care changes when a resident transitions from curative care to Palliative care and later to Hospice care.
      3. Include Sacred Space concepts
  c. Teaching Strategies
    i. Lecture
    ii. Participant Engagement through development of elevator speech
    iii. Short video

II. MODULE TWO: Communication between Support Staff, NAC's and Residents/Families
  a. Objectives
    i. Participants will be able to use some common phrases of empathy and support to comfort residents and families during this time.
    ii. Participants will be able to role play active listening strategies
    iii. Participants will be able to use silence as a communication strategy demonstrating resident/family support.
  b. Content topics
    i. How to relate to residents and families as the resident comes to the end of life
    ii. Active listening
    iii. Use of silence
    iv. Personal space and tone of voice

v. Mindfulness

c. Teaching Strategies

i. Lecture and demonstration

ii. Role play

iii. Video (Zoo movie clip) or (Close talker Seinfeld clip)

III. MODULE THREE: Role of Support Staff and NAC's in Pain/Symptom Management

a. Objectives

i. Participants will be able to define pain

ii. Participants will be able to recognize signs/symptoms of discomfort/pain

iii. Participants will know how to report signs/symptoms of pain to the nurse

b. Content topics

i. Definition of Pain

ii. How do I know if someone is in pain or suffering?

iii. What to do if you think a resident is in pain or suffering?

iv. Culture and pain

v. Last dose issues

vi. Palliative sedation

c. Teaching strategies

i. Definitions

ii. Reviewing physical signs of pain (faces)

iii. Reporting mechanism and follow up

iv. Role play signs and symptoms of pain

IV. MODULE FOUR: Final Hours

a. Objectives

i. Participants will be able to identify the physical and social/emotional symptoms of active dying.

ii. Participants will be able to identify two ways to support families as their loved one is actively dying.

iii. Participants will be able to state how their role may interfere with a good death experience and how they can support a good death experience.

b. Content Topics

i. What happens to a resident as they are actively dying in their last days, weeks or months i.e., Final Hours?

ii. How to know when you can let your tasks go in order to support a peaceful death?

iii. How to do tasks that must be done in a non-intrusive manner.

iv. Suffering

c. Teaching Strategies

i. Group discussion

ii. Lecture/moderation of group discussion

V. MODULE FIVE: Grief & Bereavement

a. Objectives

i. Participants will be able to recognize signs and symptoms of grief and loss in each other
ii. Participants will create a list of strategies to support each other during times of grief and loss of residents and the families they serve.
iii. Provide language that will support families immediately after a death has occurred.

b. Content Topics
    i. Define grief and bereavement
    ii. State signs and symptoms of grief
    iii. Discuss strategies to support co-workers during this time of loss.
c. Teaching Strategies
    i. Lecture
    ii. Have participants create a list of support strategies